Expansion of ARNP Prescriptive Authority

Report to the Legislature

December 22, 1992

Licensing and Certification

EXPANSION OF AUTHORITY OF ADVANCED REGISTERED NURSE PRACTITIONERS TO PRESCRIBE CERTAIN CONTROLLED SUBSTANCES

INFORMATION SUMMARY

BACKGROUND

Senate Bill 5635 introduced in the 1991 session of the Legislature, proposed expanding the authority of advanced registered nurse practitioners (ARNPs) to prescribe certain controlled substances. On August 13, 1992, Representative Dennis Braddock, Chair of the House Committee on Health Care, requested that the Department of Health conduct a review of this proposal under the "Sunrise" law. The Department conducted a review according to the criteria in the "Sunrise" law (RCW 18.120.110) and the Department's Guidelines for Credentialing Health Professions in Washington State. The Department reported its findings and recommendations to the Legislature by December 31, 1992.

The purpose of the Sunrise Act is to avoid regulation wherever possible. The concern of the legislature in this case is that an increase in the ARNPs' scope of practice does not prevent other qualified individuals from practicing within the same scope. If a proposed increase in the scope of practice does not prevent other currently licensed or non-licensed groups from practicing within the proposed scope, then the review would focus on whether the applicant group can practice safely. The review would not consider whether an increase in scope is necessary from a health profession supply perspective.

OVERVIEW OF SUNRISE PROCEEDINGS

The Department of Health began discussions with interested parties on the proposed increase in the prescriptive authority of advanced registered nurse practitioners in September 1992.

Regulatory agencies in other states were requested to provide sunrise reviews, regulatory standards, existing laws and administrative rules, or other information which would be useful in evaluating the proposal. In addition, a literature search was conducted seeking professional journal and other articles regarding the current level of prescriptive authority of ARNPs in other states.

Various agencies, associations, organizations and individuals both proponents and opponents were invited to provide information and feedback on the proposal.

The Department of Health, Licensing and Certification, Office of Health Services Development convened a diverse committee og DOH staff to review material and provide input and serve as the hearings panel on the proposal. Staff from the medical, osteopathic, pharmacy and nursing boards were invited to participate as liaisons to their respective boards. A public hearing was held in Seattle on November 9, 1992 at which attendees were given the opportunity to express opposition to or support and receive answers to questions regarding the proposal. Interested parties were given an additional ten days to submit final comments and to provide additional clarifying information requested by the panel.

Final recommendations were prepared for presentation to the Secretary of the Department of Health. The Department's summary and analysis of the proposal is outlined below, along with the Department's recommendations.

I. SUMMARY OF THE APPLICANT GROUP PROPOSAL

The lettered sections below are from Section VI. of the Guidelines for Credentialing Health Professions in Washington State. The summary of the Applicant Group's responses to each section is in bold.

A. Whether there is a serious risk to the public's life, health, or safety if the scope of practice remains as it is.

ARNPs have been legally prescribing legend drugs and Class V controlled substances in Washington for 13 years. Their prescribing practices have proven effective and safe. This is evidenced by: (1) an increased demand for ARNP services, particularly in areas of the health care system underserved by their physician counterparts; (2) high levels of patient satisfaction; and (3) minimal complaints about ARNP prescribers before the boards of nursing and pharmacy. The proposed legislation relates specifically to extending existing ARNP prescriptive authority to include additional classes of drugs rather than expanding the current scope of practice into areas in which ARNPs are not educated or experienced.

An ARNP's ability to adequately practice to his or her full potential has been weakened by the prohibition on prescribing schedules II-IV drugs. This results in fragmented, delayed and duplicative care being provided to patients. Delays in receiving necessary medications can lead to increased health risks and additional costs postponing needed treatment.

ARNPs, collaborating physicians, and pharmacists recognize the potential harm to the public if appropriate medication therapy is delayed. Innovative approaches have been developed over the past 13 years which allow an ARNP to make the decisions about controlled substance selection and dosage for their patients. This enables them to "prescribe" while technically complying with current law. These innovative approaches include the use of presigned physician prescription pads, telephone orders to pharmacists by physicians at the request and specifications of an ARNP, or physician countersignature of an ARNP's drug orders in facilities, usually long after the medication has been administered to the patient.

Where practiced, these tactics have allowed patients timely access to needed care. As widespread as they are, unfortunately, they are not available in all areas of the state. This points to the need to put into statute currently accepted, if not legal, prescriptive practices. If these mechanisms of "gaming" the system were to be eliminated, and controlled substance prescriptions originated solely from physicians and dentists in strict compliance with existing law, the public health, safety, and welfare of the people of Washington would take a serious step backward.

B. Whether alternatives to legislation are available to solve the problem and, if so, why they were rejected.

The 1973 amendments to the Nurse Practice Act (Chapter 18.88.280 (16) RCW) specifically prohibit "permitting the prescribing of controlled substances as defined in schedules I through IV of the Uniform Controlled Substances Act, chapter 69.50." Therefore, a legislative mandate to remove the restriction on schedules II through IV is necessary.

A specific issue in this area which needs to be resolved relates to Certified Registered Nurse Anesthetists (CRNAs), one of the ARNP specializations. The boards of nursing and pharmacy currently take opposing views on whether the utilization of controlled substances by CRNA's constitutes prescribing. Based upon the Board of Pharmacy interpretation, the practice of selecting, ordering and administering drugs during anesthesia care involves prescribing. Such prescribing may not be undertaken through a delegated prescriptive authority from physicians or dentists, regardless of the presence of guidelines or protocols which address such practice arrangements.

Theoretically, an expansion of the "gaming maneuvers" previously discussed could provide de facto expanded prescriptive authority to more ARNP practices, and serve as an alternative to legislative solutions. However, this only continues the misconception of who actually makes the drug decisions for the ARNP's patient, and potentially increases the liability of collaborating physicians, pharmacists and RNs. A legislative alternative is the only possibility for resolution of this issue.

C. Benefit to the public if the change in practice scope is granted.

The potential for increasing access to indicated drug therapy while minimizing duplicative services will be afforded by the proposed legislation. Specifically, the following benefits are anticipated:

1. **<u>Access to needed care.</u> There is ample evidence that ARNPs have helped to fill a void for primary care practitioners in the rural and urban underserved areas of Washington. Their role is most effective when they provide the full range of services for which they have been trained, including the prescribing of necessary medications. Patients benefit by having their needs met as quickly as possible through a delivery system that affords continuity of care. The record over the past 13 years of patient experiences with limited ARNP prescriptive authority attests to the beneficial role of ARNPs in access to care.**

2. Reduction in delayed provision of health services. Patients who require schedule II-IV controlled substances can have their condition properly evaluated and diagnosed by an ARNP. Under strict interpretation of current law, they are unable to receive the indicated medication without the involvement of a second provider. If a second provider is readily available, care may not be excessively delayed. Unfortunately, utilizing the services of a physician to repeat an exam or to merely prescribe medications is an ineffective and costly way to deliver health care in Washington. It limits the availability of the second provider to treat other patients when the second provider is, in fact, duplicating what the first provider has already done. In fact, there is little evidence to suggest that this second intervention by a physician normally changes the decisions made by the ARNP.

3. Cost savings for health care provision. The proposed legislation will help contain costs to the health care system in several ways. First, as pointed out above, less duplication of services will save money and time. Additionally, the patient is saved undue expense, risk, suffering, and time by receiving prompt treatment at a single point of service. It makes little economic sense for a patient or third party payor to incur the extra expense of a hospital emergency room visit to receive a prescription which should have been written by the ARNP in the first place.

Certain patients may choose not to seek additional services, especially from providers with whom they are unfamiliar. For example, it is well documented that patients who rely on controlled substances for the outpatient treatment of certain psychiatric disorders can enter prolonged in-patient treatment due to untimely drug management. Such patients are frequently under the care of ARNPs specializing in psychosocial problems.

There are some ARNPs who are unwilling to move to rural locations because under current law they know they cannot provide the full range of indicated medication therapy their patients might require. They are unsure if the "gaming maneuvers" necessary to provide appropriate medication to their patients would be in place in those areas. This lack of provider availability thus requires patients to endure added expense and time to travel to other areas to receive health care.

C. Accountability.

The public, as well as other health professionals with whom ARNPs collaborate, will be better served as a result of the proposed legislation legitimizing existing practice. Currently, a review of prescriptions which originate with an ARNP and are signed

by a collaborating physician make it appear that the physician prescribes controlled substances at a higher rate than the physician actually does. ARNPs are on record supporting audits of ARNP-originated prescriptions, and the boards of nursing and pharmacy could develop a model for such use. Without prescriptions signed by the originating and authorized ARNP, however, such an audit would prove misleading.

Additionally, patients have the right to know who is responsible for initiating the selection and ordering of the medications used in their care. The ARNP typically retains the responsibility of educating the patient about the use and effects of the prescribed controlled substance. Management of the patient's condition that originally warranted the controlled substance use is also carried out by the ARNP.

D. The adequacy of proposed changes in training/experience requirements to meet responsibilities of the proposed practice.

ARNPs currently must comply with rigorous education and experience requirements for initial and continued prescriptive authority. In part, ARNPs must stay current in the prescription and management of Schedule II-IV controlled substances.

The proposed legislation does not amend ARNP education and training standards specifically to cover the additional schedules of drugs. It is understood that the board of nursing, with the advice of the proposed ARNP advisory council, will monitor education and practice. The board of nursing will also update rules about initial and continuing standards for prescriptive licensure. Washington State currently has some of the most stringent requirements in the nation for the continuing education of ARNPs.

E. The extent to which the change may harm the public.

The proponents do not foresee increased public harm as a result of the proposed legislation. However, two theoretically negative impacts are addressed:

1. **More ARNPs with controlled substance prescribing authority could mean more potential for drug diversion to the public and for addiction by ARNPs. According to input from the boards of pharmacy and nursing, addiction and diversion by nursing groups are not unheard of, but they seem to be unrelated to the prescriptive authority for these drugs. Often addictions are of the street variety as opposed to drugs prescribed by the practitioner.**

   Additionally, most health care facilities recognize the potential for theft if medications are either overstocked, unaccounted for, or poorly protected. That risk would not increase because current facility drug stocking patterns are not likely to change as a result of the proposed legislation.

2. **Some third party payors argue that allowing ARNPs to prescribe Schedule II-IV substances will increase their costs because of the increased utilization of ARNP services and consequently of prescription drugs. Such a result seems highly unlikely for the following reasons:**

   a. **Nurse practitioners, like their physician counterparts, do not bill their patients (and their insurance companies) for the sole cost of writing a prescription. Third party billings are submitted for various evaluation and management services, regardless of whether a prescription, or prescriptions, are written. As previously stated, costs go up when the ARNP must refer their patient to a second provider or emergency room for needed medication. Obviously, the second provider will naturally expect payment for their services, commonly billed under a separate evaluation and management code. The proposed legislation should result in less duplication of service and, therefore, reduced cost to patients and to the third party payors.**

   b. **Medication costs are affected by prescribing practitioners through the specification of the drug selected, (e.g., generic vs. name brand) as well as through the volume of prescriptions written. ARNPs are well aware of the cost effects of their prescribing practices and tend to turn to medication therapy less frequently than their physician counterparts. Still, when medications are indicated, they should be available through the prescription of the qualified provider. There is no reason to expect that controlled substances prescribed by an ARNP will cost the patient or their insurer more than if a physician prescribed them.**

F. Impact of the proposed change on cost of services to the public.Impact on costs of administering the program.

It is anticipated that costs of indicated service will decrease when one practitioner is allowed to provide the same service that currently requires two practitioners, frequently in different locations. Additionally, it is likely that utilizing ARNPs to their full potential as prescribers will enhance competition. A common theme among health care reform proposals is that competition brings down costs, as in other market-driven sectors. Nothing in the proposed bill serves to eliminate or decrease collaborative interaction between health care practitioners where it is appropriately indicated. This proposal will reduce the cost of services to the public.

Information regarding costs to the Department of Health in implementing the proposed legislation was unavailable to the applicant group **at the time of proposal submission.**

II. ANALYSIS BY THE DEPARTMENT OF HEALTH REGARDING THE NEED FOR AN EXPANSION OF THE PRESCRIPTIVE AUTHORITY OF ADVANCED REGISTERED NURSE PRACTITIONERS TO PRESCRIBE CERTAIN CONTROLLED SUBSTANCES

Studies, information and staff findings

Many articles and documents were presented by proponents in response to issues and concerns raised regarding the expansion of prescriptive authority. Opponents did not provide articles or documents to substantiate the positions taken in their written information or oral testimony.

Serious Risk to the Public:

Oral and written testimony provided by the Office of Community and Rural Health and other proponents at the public hearing maintains that not expanding ARNP prescriptive authority would severely restrict access to primary and specialty care in rural areas. Testimony provided concluded that anesthesia services for surgery and trauma care in rural hospitals may not be accessible. Information regarding Washington's rural areas was provided which demonstrates the access problem and reliance upon mid-level providers (including ARNPs.)

Information provided in various articles, including "Comparative Analysis of Nurse Practitioners With and Without Prescriptive Authority" indicates that nurse practitioners with prescriptive authority had more experience and were more likely to practice in rural or suburban areas or in nongroup settings than ARNPs without prescriptive authority.

Staff concludes that restricting ARNPs from prescribing schedule II-IV substances contributes to a lack of access to care, thus representing a serious risk to the publics life, health or safety. This appears to creates a situation where ARNPs have the responsibility but not the authority for the prescribing of schedule drugs which is currently occurring.

Alternatives to Legislation:

As pointed out by the applicant group, Chapter 18.22.280(16) RCW of the Nurse Practice Act specifically prohibits the prescribing of controlled substances as defined in schedules I through IV of the Controlled Substances Act, only an amendment to this law will extend to ARNPs the authority to prescribe schedule drugs.

Opponents did not offer an alternative to legislation, but instead an alternative to legislative proposal. They presented as an option the recently passed California statute permitting prescribing based on variables such as site of care, type of care patient health status, type of supervision and the number of ARNPs supervised.

The Yale Journal of Regulation suggests that restrictive provisions relating to site-specific care are deterimental and have the effect of setting up a two-teir system of care. Under a California-type of arrangement, in some locations and under certain situations, ARNPs would have full prescriptive authority while under others they would not. Research information provided in various articles suggests that these provisions are needless and detrimental and legislative specifications of such professional norms is unnecessarily duplicative. ARNPs are trained to use independent professional judgement in providing care and are trained to know when to consult with and to refer to other health care providers, and that they have an ethical and a legal duty to do so when appropriate.

Staff concurs with this conclusion and recommends that the California example notwithstanding, the only alternative may be a legislative solution to expand prescriptive authority.

Benefit to the Public:

Information provided suggests that the public would benefit from the maintenance of access to the current level of anesthesia care. Prescriptive authority expansion will allow place the full range of drugs within the ARNP scope of practice. This would allow prescribing drugs which may be most appropriate, less costly, better tasting and may have less significant side effects. Staff concurs with this finding.

Additionally, staff recognizes the need for a mix of qualified health providers if quality health care is to be attained.

Adequacy of Training:

The "brevity" of an ARNP's education was raised as a concern by opponents. However, since this sunrise request was specific to the expansion of prescriptive authority, our review centered on the adequacy of an ARNP's pharmacology education. Information submitted by proponents and educators provided a comparison of pharmacology related education for various health professionals having prescriptive authority. This comparison indicated the following formal education in pharmacology:

	graduate education	continuing education
Medicine	74 contact hours	none required
ARNPs	70 contact hours	15 hours every 2 years
CRNAs	130 contact hours	15 hours every 2 years
Dentists	40 contact hours	none required

	14 hours to deliver nitrous oxide	7 hours every 5 years
	14 hours for conscious oral sedation	7 hours every 5 years
	1 year for general anesthesia	18 hours every 3 years
Podiatrists	55 contact hours	none specific to prescribing requirements

Physicians receive additional training and experience related to drug therapy in conjunction with their residency education. However, they are qualified to receive a prescriptive license at the end of their medical school training. None of the disciplines require undergraduate pharmacology preparations and the above hours represent the minimum requirement necessary to qualify for a prescriptive license upon graduation.

ARNPs currently prescribe legend drugs which are considered dangerous or life threatening. The pharmacology education ARNPs currently receive clearly prepares them to make appropriate decisions regarding drug therapy. Their pharmocology education exceeds that of both Dentists and Podiatrists (who have the authority to prescribe schedule drugs); and their continuing education requiremtns in pharmacology are more stringent than any other health profession.

Present ARNP pharmaceutical training is comprehensive and adequate to meet the responsibilities of expanded prescriptive authority. It is recommended however, that a member from the physician and pharmaceutical communities be included in the proposed Advisory Council.

Public Harm:

Various articles indicate there is no evidence suggesting harm to the public would occur if ARNPs were granted the authorituy to prescribe scheduled drugs. Existing Drug Enforcement Agency requirements apply equally to ARNPs and other health professionals who prescribe scheduled drugs. Board of Pharmacy can also apply appropriate sanctions for misuse of scheduled drugs. Board of Nursing has a disciplinary structure in place.

Although the issue of safe dispensing remains a concern, especially related to the criminal element and potential break-ins. The Nursing and Pharmacy professions are nearing agreement on the availability of drugs for dispensing. There is legitimate concern on both sides and staff recommends that this issue be carefully scrutinized.

Costs of Services:

Opponents also raised the issue of increased cost due to "ARNP parity with physicians."

No documented evidence was presented by opponents or proponents to support positions. However, based on oral testimony, staff concludes that even if some costs increased due to "parity", other costs would still be reduced by elimination of duplication and reduced emergency room visits. Additionally, staff concludes that overall costs would also be reduced due to the availability of a more cost effective mix of health care providers and strengthening of referral patterns.

Staff acknowledges that although ARNPs are traditionally very conservative in prescribing, passage of this bill would increase prescriptions and in an increase in health care expenditures for them. There would also be a cost for administering this regulation. However, the overall effect would be a net reduction in costs.

REGULATION IN OTHER STATES AND JURISDICTIONS

Inquiries were sent to professional licensing bodies in 49 states and the District of Columbia, requesting information on the regulation and prescriptive authority of ARNPs in those states. Responses from 27 states were received.

Information provided by responding states and proponents indicate that 13 states currently grant ARNPs independent legislative authority to prescribe. In eight of those states, ARNPs are authorized to prescribe controlled substances. Twenty-four states provide dependent ARNP prescriptive authority (i.e., authority in some way dependent on state-authorized physician or pharmacist approval). Within these twenty-four states, ARNPs in ten states are authorized to prescribe controlled substances. ARNPs in three other states have site-dependent, limited authority to prescribe. A summary of the various state provisions related to legal authority, prescriptive authority, and reimbursement status of ARNPs is attached.

ESTIMATED COST OF REGULATION

The cost of regulation is based on a fiscal note analysis of a 1991 House Bill related to expansion of prescriptive authority. The level of activity required by that bill, although not identical, will provide a very close estimate. Those costs are as follows:

	Estimated Cost 1st Year	Estimated Cost 2nd Year	Total
New:			
Volume (#)	600	200	800
Rate	98.19	98.19	98.19

Revenue	58,914	19,638	78,552
Renewals:			
Volume (#)	800	800	1600
Rate	24.19	24.19	24.19
Revenue	19,352	19,352	38,704
TOTAL REVENUES 1st BIENNIUM	78,266	38,990	117,256

2ND BIENNIUM

New:	
Volume (#)	200
Rate	98.19
Revenue	19.19
Renewal:	
Volume (#)	1900
Rate	27.17
Revenue	51,630
TOTAL REVENUES 2nd BIENNIUM	71,270

The statute requires the Secretary to recover the costs for management of health professions through professional fees.

III. STAFF RECOMMENDATIONS

The Department of Health recommends approval of the expansion of prescriptive authority for Advanced Registered Nurse Practitioners.

Information provided indicates that restricting availability of Schedule II-IV drugs to certain segments of the population creates a lack of access to care and represents a serious risk to the public life, health, and safety.

The alternatives presented by opponents do not appear to address the issues of ARNP training and capability of ARNPs to safely and effectively prescribe Schedule II-IV substances. These opponent alternatives seek to address the overall ability of ARNPs to function as independent providers, a topic which is not within the purview of this sunrise review.

The public would benefit by the availability of additional qualified providers, already functioning in an expanded practice capacity, to prescribe prescription drugs which may be more appropriate and less costly. ARNPs are trained to use independent judgement, deal with many of the same maladies as do physicians, consult with other health care providers, know their limits and know when to refer.

Pharmacology training requirements for ARNPs are comprehensive and adequate to meet the responsibilities of expanded prescriptive authority. However, it is recommended that the ARNP advisory committee include a licensed physician and licensed pharmacist in order to provide a broader perspective regarding specific training requirements.

Evidence provided demonstrates that expansion of prescriptive authority would not harm the public. Costs are expected to decrease, access is expected to increase, and the change will provide for the best mix of health care personnel.

A concern regarding public safety was raised due to the potential for theft or burglary of controlled substances at additional dispensing sites. There may be a need for dispensing of controlled substances when and where a pharmacy may not be accessible. It is the Department's recommendation that the nursing and pharmacy professions work to reach a resolution on this issue. The Department recommends that this issue continue to be carefully scrutinized.

No documented evidence was presented to support the position that expanded prescriptive authority would increase or decrease costs. However, it seems likely that overall cost of medical care would potentially be decreased by elimination of duplication, double billing and reduced emergency referrals for filling Schedule II-IV prescriptions.

Legal Authority	Reimbursement	Prescriptive Authority
	Alabama	
The BON promulgated R&Rs for specialty practice (NPs, CNMs and CRNAs) in 1982. Specialty practice is covered under the administrative code of the NPA.	Third-party reimbursement legislation for NPs was drafted in 1986; it passed the House but failed to get out of committee in the Senate. Third-party reimbursement for nurse anesthetists was passed in 1989. The Alabama Medicaid Agency adopted rules in 1991 that provide reimbursement for pediatric services of eligible family pediatric and neonatal NPs enrolled in the Alabama Medicaid Nurse Practitioner Program.	No current legislative authority.
	Alaska	
NPs have statutory authority to practice as NPs.	A non-discriminatory clause in the Insurance Law allows for third-party reimbursement to NPs. The R&Rs allowing PNPs and FNPs to receive Medicaid reimbursement will be implemented by early 1992.	Authorized NPs have independent prescriptive authority, including controlled drugs (Schedule II-V). A law permitting CRNAs to prescribe will be finalized by January 1992.
	Arizona	
A definition for NPs is in the NPA statute. Corresponding R&Rs outline scope of practice.	Registered NPs and other certified registered nurses receive third-party reimbursement. Enabling statute is in Department of Insurance statutes. NPs also receive Medicaid reimbursement consistent with the Federal law.	NPs have full prescriptive and dispensing authority upon application and fulfillment of criteria established by the BON. The enabling statute allowing CNPs to prescribe is in the pharmacy statute, with corresponding R&Rs in the NPA. NPs are provided their own DEA numbers and may prescribe Schedule II and III drugs (limited to a 48-hour supply per patient) and Schedule IV and V (a one-month supply with no refills per patient). Other drugs may be refilled five times or up to one year.
	Arkansas	
NPA legitimizes practice for NPs, CRNAs and LNMs; there are separate R&Rs for NPs.	Some private carriers do reimburse RNs directly; Medicaid reimburses licensed CNMs. In 1991, the state Medicaid office enacted the Federal requirement to grant provider status to certified FNPs and PNPs. Due to state nursing association efforts, NPs are reimbursed at 80 percent of the physician rate for all applicable service codes.	No current legislative authority; Board of Pharmacy did pass a special waiver for a limited number of drugs for women's health NPs who work for the Department of Health. These prescriptions are preprinted and cannot be altered. The NPs print a physician's name and then their own.
	California	
The BRN issues certificates to CNMs and CRNAs. NPs who meet the BRN requirements are so designated on their licenses.	A new law took effect Jan. 1, 1992, that requires Medi-Cal to reimburse FNPs and PNPs for Medicaid covered services. Psychiatric clinical nurse specialists are also eligible to receive third-party reimbursement.	Prescriptive authority for NPs and CNMs has been expanded under a law effective Jan. 1, 1992. To "furnish drugs and devices," NPs must obtain a number from the BRN after completing a pharmacology course and a six-month preceptorship with a physician. NPs and CNMs may furnish non-controlled substances under standardized procedures "incidental to the provision of family planning services, routine health care and perinatal services" in most health care sites (except offices of solo health care practitioners).
	Colorado	
There is no title protection or specifications for advanced practice within the NPA. The act is broad to cover NPs; scope of advanced practice is based on RN's own determination of education and experience and amount of physician supervision necessary to conduct practice safely.	Third-party reimbursement is available to any RN; billed services qualify for reimbursement only if the type of service has a history of being reimbursable to another health care provider (i.e., a fiscally neutral bill). Medicaid reimbursement is available to PNPs, FNPs and CRNAs as of Oct. 1, 1990, as regulated by Department of Social Services.	There is no independent prescriptive authority, but there are prescriptive privileges under "delegated medical acts" specified within the NPA and MPA. NPs may write Rx for drugs pursuant to a protocol.
	Connecticut	
Advanced practice is recognized in the NPA, but the title APRN is specific only for the purpose of prescriptive privilege. The Declaratory Ruling by the BON requires that all nurses in advanced practice be nationally certified.	Certified nurse practitioners, certified psychiatric mental health clinical nurse specialists and certified nurse midwives are reimbursed for services rendered based on state insurance statute. The statute only affects private insurers. Nurse providers must have a fee-for-service practice, either private or collaborative. Services reimbursed must be within individual's scope of practice and must be services that would be reimbursable if provided by any other health care provider.	Nurse practitioners, clinical specialists, nurse midwives and nurse anesthetists may apply for prescriptive practice privileges, including controlled substances. APRNs must apply for licensure in order to prescribe and are required by law to be nationally certified, have 30 hours of pharmacology, and to have a master's degree if nationally certified after Dec. 31, 1994. Dispensing privileges are also granted to APRNs functioning in specified settings; additional practice settings will be delineated in regulations.

Legal Authority	Reimbursement	Prescriptive Authority
Delaware		
R&Rs for ARNPs were promulgated by the BON in May 1991. Applicants must have a full academic year of post-basic education, plus national certification requirements. There will be an individual applicant review through May 1992 for applicants not meeting requirements.	An insurance act effectve Jan. 1, 1991, specifies that no health insurer, health service corporation or HMO shall deny benefits for eligible services when rendered by an ARNP acting within his/her scope of practice. CNMs obtained legislative authority under the Board of Health for third-party reimbursement in October 1988. FNPs and PNPs also receive Medicaid reimbursement.	There is no current legislative prescriptive authority, but the issue is being studied seriously.
District of Columbia		
NP practice is defined in the Health Occupations Revision Act (1986); NPs are under jurisdiction of the BON. NPs must work in collaboration with physicians or osteopaths.	There is no current legislative authority for NPs to receive third-party reimbursement, but NPs are eligible for Medicaid reimbursement.	The D.C. statute provides for prescriptive authority for NPs, nurse midwives and nurse anesthetists. R&Rs authorize prescribing Class II-V drugs according to existing federal laws.
Florida		
NPs are certified by the BON as ARNPs. CNMs, CRNAs and CNSs in psych-mental health are also certified as ARNPs.	ARNPs receive Medicaid, Medicare, CHAMPUS and third-party reimbursement.	Prescriptive privileges were obtained for NPs in May 1988 as a result of a decision by the BON/ BOM joint committee; controlled substances are excluded.
Georgia		
The NPA gives authority to the BON to set R&Rs for NPs, CRNAs, CNMs and clinical specialists in psych/mental health. The current R&Rs specify that NPs should work within protocols that have been jointly developed by the NP and collaborating MD or agency. The protocols are not currently evaluated by any state licensing board.	FNPs and PNPs are eligible for Medicaid reimbursement from the Department of Medical Assistance: Some private insurers reimburse NPs but are not required by law to do so.	There is no independent prescriptive authority for NPs. However, House Bill 209 (passed in 1989) states that through a protocol a physician may delegate to a nurse in advanced practice the authority to order controlled substances or dangerous drugs.
Hawaii		
There is broad language for advanced practice, but NPA does not specify advanced practice. Rules and/or language changes in the NP act may occur in 1992.	NPs are reimbursed through CHAMPUS. Rules are being developed for reimbursement through Medicaid.	The NPA is broad but may need legislative authority through additional statutes. Plans are to submit a bill to the 1992 legislative session calling for authority for advance-practice nurses.
Idaho		
Rules for the NP are jointly promulgated by BON and BOM. A bill was introduced in 1991 legislative sessions to eliminate the requirement for joint promulgation. The bill was held in committee in a tie vote.	NPs may apply for a Medicaid reimbursement number. Current legislation seeks third-party reimbursement for nurses in mental health.	Prescribing is allowable for approved NPs based upon a formulary in the rules; NPs may not prescribe controlled substances. The formulary was expanded with a rule revision, effective Sept. 5, 1991.
Illinois		
The NPA's definition of nursing practice contains no reference to advanced practice. By legislative intent and the position of the Department of Professional Regulation, advanced specialty nursing practice falls within the definition of professional nursing. Nursing practice must stay within "the scope permitted by law and within the RN's own educational preparation and competencies."	Third-party reimbursement is not addressed in the NPA. It is found in the Public Aid statute and regulation, and is consistent with federal mandates.	No current legislative authority, but legislation on prescribing authority is planned for next session.
Indiana		
NP practice is defined in NPA with qualifications "as determined by BON"; the BON has not yet adopted R&Rs.	NPs may receive direct third-party reimbursement as determined by payers.Though NPs can receive provider numbers, there are no guidelines for reimbursement, so NPs are not receiving any money.	No current legislative authority.
Iowa		
Advanced-practice administrative rules are in the NPA. ARNPs are licensed by the BON.	There is legislation that permits third-party reimbursement for certified RNs.	Legislative authority to prescribe non-controlled substances was granted to ARNPs (excluding CRNAs) in the 1991 session. R&Rs are being drafted currently, with an anticipated effective date of June 1992. The statute gives the BON responsibility for administering the prescriptive authority. The R&Rs must be drafted in consultation with the BOP and must be accepted (not approved) by the BOME.

Legal Authority	Reimbursement	Prescriptive Authority
Kansas		
Advanced practice recognition is voluntary for ARNPs (CNMs, NPs and clinical nurse specialists). There is mandatory recognition for CRNAs.	A statutory requirement to reimburse all ARNPs for currently covered services in health plans was passed in 1990. Five urban counties are excluded from this provision. Medicaid has expanded payment to include all covered services but will only pay 80 percent of physician payment (except for CRNAs, who receive 100 percent, and practitioners performing early periodic screening diagnosis and testing, who also receive 100 percent).	NPs may prescribe under jointly adopted protocols between the nurse and physician. The BON has adopted R&Rs for permanent regulations that allow ARNPs to prescribe following jointly agreed upon protocols with "the responsible physician," excluding controlled substances.
Kentucky		
State law licenses ARNPs (including nurse practitioners, nurse midwives and nurse anesthetists).	As of Oct. 1, 1990, the state medical assistance program reimburses NPs for services.	A legislative bill clarifying ARNP prescriptive privileges was not successful in 1990. ARNPs currently may prescribe according to established protocol under the authority of state administrative regulations. Clear statutory language for prescribing will be sought in 1992.
Louisiana		
R&Rs for NPs are promulgated by the BON.	Medicaid reimbursement has been provided for CNMs and CRNAs. R&Rs for CFNP and CPNP reimbursement are underway with the Bureau of Health Financing.	No current legislative authority.
Maine		
The NPA authorizes medical diagnosis or prescription of therapeutic or corrective measures when those services are delegated by a licensed physician to an RN who has completed the necessary additional education program approved by the BON. The BON may adopt rules defining the scope of practice for nurses and the appropriate relationship with physicians.	Reimbursement available for master's-prepared, certified psych/mental health nurse specialists. Medicaid reimburses for services provided by CFNPs, CPNPs and CNMs.	Prescriptive authority is approved by BOM (NPs have their own DEA numbers). Limits in prescribing formulary by exclusion (i.e., narcotics).
Maryland		
NPs are certified to practice through the BON; requirements include passing a nationally certified exam and written agreement with a responsible MD (the agreement is reviewed by an equally represented joint MD/NP committee).	Per legislation passed in 1986, all nurses are entitled to private third-party reimbursement for services as long as they are practicing within their legal scope of practice. Medicaid reimbursement for NPs was passed by state Legislature in May 1990.	NPs have prescriptive authority, including controlled substances, as agreed upon in a written agreement with a responsible physician. In 1991, some NPs were denied federal DEA numbers because of the proposed change in federal DEA regulations. State DEA numbers are still being issued, and federal renewals are being granted.
Massachusetts		
Since 1975, nurses with additional education approved by the BON may perform certain additional acts under R&Rs approved by the BON and BOM. This includes NPs, CNMs, CRNAs and psychiatric nurse/mental health clinical specialists.	Psychiatric nurse/mental health clinical specialists and midwives are currently reimbursed due to state law. Bills are pending before the Legislature on reimbursement for NPs and CRNAs. Though PNPs and FNPs will be reimbursed for Medicaid patients, the R&Rs have not yet been finalized.	NPs, after registering with the Department of Public Health, may prescribe for patients in long-term-care facilities as well as for chronic-disease patients in their homes, if this would avoid their institutionalization. A bill is pending that would extend NPs' prescriptive authority; passage in 1992 is anticipated. CNMs who register with the Department of Public Health may also prescribe according to certain guidelines.
Michigan		
The BON has R&Rs for nurse specialty certification — only nurses certified in a specialty field may present themselves to the public as nurse specialists using the title of nurse anesthetist, nurse midwife and nurse practitioner.	Though there is no legislation addressing third-party reimbursement, several NPs and CNMs have obtained provider numbers with private insurers. CNMs are eligible providers for Medicaid reimbursement and selected Blue Cross/Blue Shield contracts. Medicaid directly reimburses certified FNPs and PNPs at 100 percent of the reimbursement rate.	A January 1980 attorney general decision interpreted the statutes to allow physicians to delegate the prescribing of drugs to RNs, excluding controlled substances.
Minnesota		
NP authority to practice is covered under a broad NPA; there is no separate category for advanced practice.	NPs, CNMs, CRNAs and clinical nurse specialists in psych/mental health have legislative authority for reimbursement. FNP, PNPs, GNPs and ANPs are reimbursed by Medicaid at 75 percent of the physicians' rate; Ob-Gyn NPs are reimbursed at 65 percent of the physicians' rate.	CNMs received authority to prescribe in 1988. In 1990, NPs received prescriptive authority for non-controlled substances (when delegated to do so under a written agreement with a physician).

Legal Authority	Reimbursement	Prescriptive Authority
Mississippi		
ANPs, FNPs, PNPs, FPNPs, CNMs, CRNAs, neonatal NPs and Ob/Gyn NPs are regulated and licensed by the BON. R&Rs regarding NP practice are jointly promulgated by BON and BOM. A BON-sanctioned committee structure (consisting of NPs and consulting MDs) evaluates (every two years) each NP's "protocols" (written statement of the types of medical diagnoses and treatments anticipated for their practice).	NPs in rural health clinics receive federal reimbursement. Third-party reimbursement for NPs was first passed in the early '80s but that law had a "sunset" clause and required an MD sponsor co-signature. The '88 legislative session removed the "sunset" clause but retained requirement for MD cosignature. Effective July 1, 1990, Medicaid reimbursement is available. Reimbursement is 90 percent of what a physician's payment would be.	NPs have statutory prescriptive authority granted by BON; the prescriptive authority is based on the accepted "protocol," which lists the treatments and medications the NP expects to prescribe in his or her practice. NPs are not allowed to prescribe controlled substances.
Missouri		
Advanced practice is permitted based on broad language of the NPA, and a decision by the Missouri Supreme Court.	Legislation provides for direct reimbursement of FNPs, PNPs and CNMs in line with OBRA '89 regulations. Blue Cross/Blue Shield has a statutory non-discriminatory policy for licensed health care providers. Whether other types of insurance reimburse NPs depends on the company policy.	There is no statutory prescriptive authority. Authority to prescribe non-controlled medications is granted through standing orders/protocols with cooperating physicians.
Montana		
Nurse specialists (NPs, CNMs and CRNAs) are recognized and allowed by the BON to practice after completion of specific curriculum requirements, plus successful completion of a certifying exam by a recognized certifying body.	Nurse specialists have third-party reimbursement for all the areas and services for which a policy would reimburse an MD. Medicaid reimbursement has been available for all nurse specialists since 1986. Medicare reimbursement consistent with federal guidelines (1990) is currently in effect; nurse specialists are negotiating for additional covered services.	In 1989 nurse specialists were granted prescriptive authority. R&Rs were drafted in 1991 by a committee from the BON, BOME and Board of Pharmacy, and nurse specialists. Nurse specialists can prescribe all medications, including controlled substances II-V, using their own DEA numbers. Prescribing nurse specialists must have a quality-assurance program in place with a defined process of referral. Nurse specialists must complete CE requirements prior to application.
Nebraska		
NPs are certified as CNPs on approval by BON and BOM. CNPs and MDs must have joint approval of their "practice agreement" contract, i.e., the NP's scope of practice and the practice arrangement with the MD. NPs must have written protocols for clinical entities seen. Changes must go through the Department of Health (BON and BOM).	Except where federally mandated, there is no state legislation for third-party nursing reimbursement.	NPs may prescribe as specified on the "practice agreement" form. Drugs prescribed must be listed on NPs' protocols and may not include Schedule II drugs.
Nevada		
An advanced practitioner of nursing (APN) is recognized by BON (title includes CNMs). Applicant must submit a signed agreement (including the scope of practice and protocols) between the APN and the collaborating MD. Prior to July 1992, applicants must show documentation of practice for three of the past five years (or be a recent APN graduate). After July, all APN applicants must be either nationally certified, or hold a BSN or sign an agreement with the BON to make consistent progress toward the degree. National certification is not required.	NPs and CRNAs have received third-party reimbursement since 1985. Some other nurses in private practice also receive third-party payment. Medicaid reimbursement is available to NPs.	APNs may prescribe (since 1983) if they submit to the BON documentation of 1,000 hours as an APN under a collaborating MD and a signed statement from the MD. APNs must also apply to the Board of Pharmacy for a certificate to prescribe. If approved by the BON and BOP, the APN can prescribe any meds (excluding controlled substances) listed in his or her protocol (developed by the collaborating MD and updated yearly).
New Hampshire		
NPs are registered with the BON as ARNPs (if the NP is a graduate of an NP program and has passed a certifying exam acceptable to the board).	All major insurance companies, hospital service corporations, medical service corporations and non-profit health service corporations must by law reimburse ARNPs when the insurance policy provides for any service that may be legally performed by the ARNP, and such service is rendered. Medicaid also reimburses eligible NPs.	A BON-approved ARNP may prescribe controlled and non-controlled medications from the official formulary determined by at least five members of the Joint Health Council, which consists of two from the BON, two from the BOM, one MD and two from the BOP. ARNPs are assigned DEA numbers upon request and approval of application.
New Jersey		
NPs practice under RN licensure with BON guidelines for primary care NPs.	There is Blue Cross/Blue Shield third-party reimbursement (for services traditionally reimbursed to MDs) for RNs and NPs who are not employed as salaried personnel. NPs are aggressively lobbying the Medicaid office for PNP and FNP reimbursement.	Proposed legislation (to be approved by full Assembly in January) would allow BON-qualified NPs and CNSs to "order medications and drugs" in accordance with standing orders or joint protocols (updated and signed annually) developed by the collaborating MD and NP/CNS. The script would contain NP/CNS signature, printed name and certification number, and printed name of collaborating MD.

Legal Authority	Reimbursement	Prescriptive Authority
New Mexico		
A 1991 revision to the NPA defines advanced practice as being in collaboration with a physician. The NPA defines both independent and interdependent functions.	Statutory authority for third-party reimbursement for NPs and CNSs has been in effect since 1987. FNPs and PNPs receive Medicaid reimbursement.	The 1991 NPA revisions give NPs statutory authority for prescriptive privileges. NPs may prescribe non-controlled substances with the supervision of a physician.
New York		
Specific legislation amending the Education Act to authorize NPs' title and scope of practice became effective April 1, 1989.	Regulations permitting Medicaid reimbursement of NPs became effective June 6, 1990. The fee schedule pays appropriately for services rendered regardless of type of provider.	The new law specifies Rx authority for NPs in a collaborative relationship with MD and with written practice agreement and protocols. The law states "prescribed drugs, devices and immunizing agents" without restriction (i.e., controlled substances). NPs have applied for DEA numbers but none have been issued. The state attorney general has been asked to interpret the law to determine if NPs have independent or derivative prescriptive authority, since the federal DEA has said it will issue numbers only to practitioners with unrestricted, independent prescriptive authority.
North Carolina		
NPs apply to a joint subcommittee of the BOME and the BON to obtain approval to practice as an NP. NPs may own their own private practice as long as they contract with an MD (not necessarily on site) to act as medical backup and provide a clearly defined procedure for emergencies.	NPs receive Medicaid and CHAMPUS payments only.	NPs may write prescriptions from an approved list of drug categories (i.e., formulary by exclusion; no Class IV drugs). Authority to prescribe (NP is assigned a prescriptive number) is given at time of approval to practice as an NP.
North Dakota		
Advanced practice for NPs, clinical nurse specialists, nurse clinicians, nurse midwives and nurse anesthetists is regulated by the BON after demonstrated advanced education and certification. ARNPs must maintain national certification and submit a scope-of-practice statement for review by the BON in order to renew their ARNP license.	A bill for nurse reimbursement was passed in the 1985 legislature but amended to make it useless. In 1987 a bill was passed giving benefits for health services provided in the scope of licensure by nurses holding advanced licensure and having a scope of practice within mental health.	A bill authorizing prescriptive authority to ARNPs for controlled and non-controlled drugs was passed by the 1991 Legislature. Completion of the BON R&Rs is anticipated for February, 1992. ARNP applicants for prescriptive authority must 1) provide evidence of 30 hours of pharmacotherapy education within the last three years; 2) submit a scope of practice that includes the nature and extent of physician collaboration and consultation; 3) include a statement from the physician clarifying the ARNP's planned prescriptive practices. Names of ARNPs granted prescriptive authority will be forwarded to the BOP.
Ohio		
The NPA contains no language for NP title protection. Under BON R&Rs effective April 1991, RNs may use a title denoting specialty certification if they are certified by a BON-approved national certifying organization. The title that should be used is the title granted by the national certifying organization.	Some RNs, including NPs, are receiving reimbursement as a result of direct negotiations with insurance companies. The BON is working with a formal coalition to promulgate R&Rs on scope of practice to enable the Dept. of Human Services to assign Medicaid provider numbers.	The formal coalition is currently looking at legislative and non-legislative prescriptive authority for nurses with specialty certification. Action is anticipated within the next year.
Oklahoma		
NPs are defined in NPA and regulated by BON; NPs must have successfully completed a program approved by BON and be nationally certified as an NP.	There is no current legislation addressing third-party reimbursement for NPs.	There is no current legislative authority.
Oregon		
Authority for NP practice is granted through the NPA and regulated by BON. Scope of practice is very broadly defined in statute; a master's degree is required for entry into NP practice.	NPs are directly reimbursed by third-party payers by law. Exceptions include HMOs, PPOs, etc., which has been a problem. Medicaid also reimburses FNPs and PNPs.	NPs have BON-regulated prescribing authority, excluding controlled substances. A council consisting of NPs, MDs and pharmacists determines the formulary from which NPs can prescribe. NPs must have a postgraduate pharmacology course to be certified to prescribe.
Pennsylvania		
Registered nurses who are certified by the BON and BOM as certifed registered nurse practitioners may function in an expanded role under the 1977 R&Rs for the CRNP.	Third-party reimbursement is available for the CRNA, CRNP, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse and certified CNS, provided the nurse is certified by the state or a national nursing organization recognized by the state BON. Medicaid reimburses all CRNPs.	The CRNP R&Rs authorize the CRNP to "perform acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in the Commonwealth."

Legal Authority	Reimbursement	Prescriptive Authority
Rhode Island		
NP advanced practice is covered under the NPA. A joint-practice committee (three MDs, three NPs and one consumer) meets regularly to assess CRNP joint primary care practice for the purpose of improving patient care and to review complaints. This committee reports periodically to the BON.	There is legislation for direct reimbursement of psychiatric clinical specialists and CNMs (June 1990). January 1992 legislation allows CRNPs and psychiatric and mental health CNSs working in "health centers licensed by the Department of Health" to receive third-party reimbursement. Medicaid legislation has been passed but has not yet been implemented.	Legislation authorizing prescriptive authority passed in July 1990; the finalized R&Rs are anticipated by February 1992. A six-member formulary committee appointed by the director of health has determined what the formulary contains: legend drugs and no controlled substances. The CRNP and collaborating MD determine their own practice guidelines, which are kept at the practice site and updated and signed annually. The legislation specifies that the CRNP has prescriptive authority in "health centers licensed by the Department of Health" (i.e., hospitals, physician offices, university and college health centers, Planned Parenthood clinics, nursing homes, and private, non-profit, organized, ambulatory-care facilities).
South Carolina		
Advanced-practice nurses must be officially recognized by the BON and must have MD preceptors to practice in the extended role. For the sections of their practice related to "medically delegated acts," NPs must have protocols codeveloped, dated and signed by the MD and NP. The BON conducts a random survey of the protocols.	Since July 1, 1990, FNPs and PNPs can apply for a Medicaid provider number; they are paid 80 percent of the amount paid to physicians for like services. The state health and human services finance commissioner requires NPs to have current, accurate and detailed treatment plans.	No current prescriptive authority but dialogue is underway between the BON and BOME to look at this issue.
South Dakota		
To become CNPs, NPs must submit a practice agreement that is approved by BON, BOM and Osteopathic Examiners representatives. CNPs must work under the supervision of an MD, but the MD is not required to be on site at all times.	The insurance law since the early '80s specifies that NPs and CNMs can receive third-party reimbursement. The most prominent payer, Blue Cross/Blue Shield, has assigned provider numbers to NPs. NPs also receive Medicaid reimbursement.	CNPs may prescribe because prescribing is considered a delegated medical function. CNPs and their supervising MD must submit their "practice agreement" (including the CNPs' scope of practice) to the joint board; the agreement is filed with the BON. CNPs act as the agent of the primary supervising physician in providing and prescribing (except for Schedule II controlled substances). CNPs do not receive DEA numbers; they use their primary supervising physician's name and DEA number.
Tennessee		
RNs functioning in an expanded role assume personal responsibility for their acts. RNs who manage the medical aspects of a patient's care must have written medical protocols, jointly developed by the nurse and the sponsoring MD(s). The detail of medical protocols varies in relation to the complexity of the situations covered and the preparation of the RN using them.	Legislation providing for direct Medicaid reimbursement was passed for CRNAs in 1987 and for CNMs in 1988. Legislation to mandate Medicaid reimbursement for certified NPs was introduced in 1991, but didn't move out of the House and Senate Finance committees. There is no law mandating reimbursement from private payers, though some NPs receive reimbursement on an individual basis.	Master's-prepared NPs who are certified through ANA, ACNM and NAACOG and who have specified pharmacology courses may apply to BON for a "certificate of fitness" with privileges to write and sign prescriptions and/or issue non-controlled legend drugs. "Certificate of fitness" must also be approved by the Primary Care Advisory Board for the site of practice, and recorded by Division of Health Related Boards.
Texas		
Advanced practice (CNM, CRNA, clinical nurse specialists and all NPs) is regulated under the title of "Advanced Nurse Practitioners." Those who hold themselves out to be ANPs and/or use titles that imply they are ANPs must have their credentials approved by the BONE.	There is nothing in the law that mandates private third-party reimbursement for NPs, but some companies elect to reimburse certain NPs. FNPs, PNPs, CNMs and CRNAs are eligible for direct Medicaid reimbursement.	Legislation effective Sept. 1, 1989 (as part of the Omnibus Rural Health Rescue Act), allows ANPs and physician assistants prescriptive authority under standing orders or protocols; prescriptions must be "presigned." ANPs are required to meet special education and training, including pharmacology as required by the BONE. To be authorized to prescribe, the ANP must serve certain medically underserved populations.
Utah		
NPs are licensed by BON; since 1987 all NPs must be master's-prepared. Physician collaboration is required only for NPs' prescribing scope of practice.	There is a nondiscrimination clause in the state insurance code, so there is nothing to prohibit reimbursement. NPs are reimbursed by some insurance companies; NPs have not organized to challenge the others. The state Health Department advisory board has implemented PNP and FNP reimbursement at 100 percent.	All NPs in practice with an MD can apply for prescriptive privileges. The MD need be only in telephone contact with the NP (i.e., does not need to be in the office). Protocols are developed by the MD and NP and are submitted for approval to the prescriptive board, consisting of three NPs, three MDs and a pharmacist. NPs can prescribe controlled substances III-V.

Legal Authority	Reimbursement	Prescriptive Authority
Vermont		
Advanced practice is controlled by BON under the NPA. The NP who meets BON criteria applies for endorsement with or without "medical acts" (depending on the NP's scope of practice). The NP who is endorsed with "medical acts" must function within protocols mutually agreed upon by the NP and the collaborating MD. These protocols are reviewed and signed annually by the NP and collaborating MD.	Currently, Blue Cross/Blue Shield reimburse psychiatric NPs utilizing a provider number. FNPs and PNPs receive Medicaid reimbursement.	Prescriptions, including controlled substances, may be written and signed by the NP for those drugs covered in current protocols. A list of BON-endorsed NPs is made available to the Board of Pharmacy.
Virginia		
The MPA authorizes advanced practice under R&Rs jointly promulgated by BON and BOM (includes NPs, CNMs and CNAs). Clinical specialists are registered solely with the BON. Registration is voluntary.	There is no current legislative requirement to pay NPs. Third-party reimbursement for CNSs in psych/mental health was signed into law in February 1989; R&Rs were effective March 1990. NPs may receive federal reimbursement.	Prescriptive authority enabling NPs and CNMs to prescribe schedule IV drugs was signed into law February 1991. R&Rs are scheduled for completion in mid 1992.
Washington		
Advanced practice is authorized by the BON for ARNPs.	Legislation states that benefits shall not be denied for any health care service provided by a nurse practicing within the lawful scope of that nurse's license provided such services would have been reimbursable if provided by a physician. The legislation pertains to private insurers and health care service contractors. Medicaid reimbursement is also available to NPs.	Legislation for prescriptive authority for schedule V and legend drugs is authorized under the BON and entails a minimum of 30 hours of pharmacotherapeutic education within the specialty area.
West Virginia		
R&Rs defining advanced practice for RNs took effect July 1991. A licensed RN may announce advanced practice if s/he has BON-recognized national certification. Beginning January 1999, all advance practice RNs must have an MSN. A special license is not issued; the RN license shows the title granted by the approved national certifying body.	There is a law requiring insurance companies to reimburse nurses for nursing services, if such services are commonly reimbursed for other providers; however, R&Rs have not been promulgated.	No prescriptive privileges at this time; however, legislation was proposed during the 1991 session but did not come up for a final vote. Plans are to reintroduce it in the 1992 session.
Wisconsin		
NPs function under an NPA with a broad description of nursing practice; there is no specific definition of advanced practice.	There is 100 percent Medicaid reimbursement for all master's-prepared NPs or NPs certified by ANP, NAPNAP or NAACOG. NPs are also reimbursed by Medicare for NP services to residents in nursing homes or residents of rural areas. CHAMPUS reimburses NPs, and home health RNs bill under their own provider number. Third-party reimbursement has not been addressed legislatively.	The NPA does not specifically use the word "prescribe," but RNs in Wisconsin may prescribe (including controlled substances) as a delegated medical act under the NPA (Chapter 441, Wis. Stats.) and under Chapter N6, Wisconsin Administrative Code, if the requirements in Chapter N6 are met.
Wyoming		
The NPA gives authority for BON to recognize advanced-practice nurses (APNs) after demonstrated advanced education or certification.	The Public Health Department plans to introduce a bill to the 1992 Legislature that would authorize Medicaid payment to APNs. The current state statute says that all primary health care providers should receive third-party reimbursement. The state insurance commissioner has said he will handle any problems APNs have with claims.	The 1991 Legislature passed a bill authorizing BON-approved APNs to prescribe independently legend and controlled substances (III-V). APNs must show: 1) proof of 30 hours of pharmacotherapeutic education within the last five years; 2) a statement declaring personal or professional liability coverage; 3) a copy of their collaborative practice agreement, which specifies in writing the APN's medical referral plan for critical or complicated medical situations requiring a DDS or physician. BON provides a list of approved APNs to the BOP.

Educate Your Legislators

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